COMMENTARY

ON NATIVE AMERICAN HEALTH CARE

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Federal Programs and Indian Country: A Time for Reinvention

THE LEADERS OF the American Indian and Alaska Native communities, particularly the elected leaders of the more than 500 tribal governments, face a formidable task in their efforts to protect and promote the health of American Indians and Alaska Natives. They recognize that providing medical care is only part, and often a small part, of the problem. Economic development, jobs, education, child care, family support, community support, housing, and public health (particularly safe water, sewage, nutrition) are all essential to assuring that the health of American Indians and Alaska Natives is what it could and should be.

The widely varied socioeconomic status of tribes is reflected in the health status of tribal members. When poverty and unemployment are widespread, the health of the population is poor—high rates of infant mortality, premature death, and disability; often widespread tobacco use and alcohol abuse; and high rates of teenage pregnancy. In tribes where the environment is not so harsh and the economic conditions are better, the health of the tribal members is equal to or better than neighboring populations or the health of the U.S. population as a whole, but not without strong tribal leadership and community involvement.

The Federal government has a clear role to play in support of these leaders, especially those of Federally recognized tribes with whom there is a special government-to-government relationship, much like that of the United States with foreign governments—a recognition of tribal sovereignty and rights to self-determination. There is also a broad array of treaty obligations, Executive Orders, and Congressional legislation that defines the partnership envisioned between the Federal government and Indian tribal governments.

As with any such partnership, if one party fails to meet its obligations, the overall goals, though they may be shared, may not be reached. Over the years, the U.S. gov-

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ernment has not been a reliable partner in meeting its obligations to Native American people in a variety of areas from religious rights to land use to health care. Despite some efforts by the Clinton administration to coordinate Executive Branch activity with tribes through a Domestic Policy Council Working Group chaired by Secretary Babbitt, there has not been the kind of systematic review of how the current structure and function of Federally funded Indian programs fits the realities faced by Indian people.

One example of the need for this kind of reexamination is particularly apparent in the area of health and social welfare. Because of the historic government-to-government relationship between tribes and the Federal government, the kinds of devolution of program authority—and, often, resources—to state governments fundamental to the recent welfare reform and state Medicaid waiver programs require involvement of tribes in planning for the design and management of these program changes. The Federal government must also meet its obligations to assure that states understand and respect the rights of tribes in such programs, as tribal-state relations are highly variable, often antagonistic. Finally, Native American people not living on reservations must be protected from the discrimination often faced by people of color.

As the Federal government's direct health service program, the Indian Health Service (IHS) has been one of the most reliable of U.S. government agencies since it came over to the Department of Health and Human Services as a part of the U.S. Public Health Service in 1955. However, as noted in the Noren et al. article,1 the IHS has never been adequately funded, staffed, or equipped to meet the needs of American Indians living on reservations or Alaska Natives living in villages. The legislation governing its use of funds also fails to reflect the fact that nearly 60% of Indian people live off reservation in cities; funding for services to them meets less than 20% of estimated need and reflects less than 2% of the entire IHS budget.

Because of legislative or administrative constraints, the IHS lacks a series of managerial freedoms that are fundamental to the survival of private sector health care providers in the current market environment. It lacks the authority to enter into risk contracts with state Medicaid programs at a time when states are moving rapidly to managed care Medicaid plans. It is burdened by a cumbersome and inadequately funded capital budgeting process dependent on annual Congressional funding decisions that leaves projects for critical new facilities languishing in the pipeline for years while existing facilities deteriorate from inadequate maintenance. It lacks authority to operate with a flexibility in procurement, personnel, and contracting that would permit smoother relationships with tribes as they take over responsibility for their own programs and facilitate the kind of decentralization of the IHS that all agree is necessary to allow it to be more responsive to the communities served.

Because of the resource constraints, what funds there are have been directed into clinical services, leaving no support for the kind of human resource development program called for in the Noren et al. paper. As noted, training, especially in leadership, operations, and financial management, is badly needed in the IHS as well as in tribally run programs. The blueprint for the future structure and function of the IHS has been charted by the Indian Health Design Team, a group composed predominantly of tribal leaders initiated by Dr. Michael Trujillo, the Director of IHS. The vision is one of a decentralized health system, some parts run directly by the IHS and others by tribes, all responding maximally to local needs and health conditions.

The Noren et al. paper provides a clear and valuable organizational analysis of management needs; action is now required to provide the resources and develop the program to meet those needs. Further, the current legislative and regulatory constraints within which the IHS and tribal health programs must operate need to be examined with an eye to "reinventing" policy and practice for a modern health sector to serve American Indians and Alaska Natives as we enter the 21st century. The leadership and expertise are clearly available for this task, within the IHS and the tribes and within DHHS, the Office of Management and Budget, and among those Congressional leaders who have played such an important role in support of Indian programs over the years. The key is joining together to seize an opportunity of a generation to assure that all the partners are meeting their obligations to promote and secure the health of Indian people.

Such an opportunity is also present in other sectors of government, and the Clinton Administration has articulated, since its beginnings, the importance of government meeting its responsibilities to tribes. Now is the time to launch a broad-based review of Federal programs for American Indians and Alaska Natives, applying the reinvention principles of government reform promoted by Vice President Gore and conducted in a partnership with tribes and Congressional leaders. In this way, this administration can leave the legacy of a strong foundation for the future of the Federal-tribal partnership.

Reference

1. Noren J, Kindig D, Sprenger A. Critical challenges facing Native American health care. Public Health Rep 1997 112:22–33. ■